CHORUS BLOG:

Fragmentation in urban health service provision? A plurality of providers is the answer

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The majority of the world's population is now urbanised, with 55% of humanity currently living in urban areas. According to the United Nations, the number could go up to 68% by 2050. Low- and Middle-Income Countries (LMICs) are experiencing this sharp increase in urban populations. According to the United Nations' World Urbanization Prospects 2025, Dhaka, the capital of Bangladesh, currently has a population of around 36.6 million. By 2050, it is projected to become the world's most populous city, reaching 52.1 million.

CHORUS is a Research Programme Consortium that brings together health researchers from Africa, South Asia and the UK. CHORUS works with communities, health professionals and city level decision makers to develop and test ways to improve the health of the poorest urban residents.

This rapid urbanisation comes with a toll on city authorities especially in the healthcare sector, which is also often described as fragmented. In some LMICs, public hospitals operate in isolation, private clinics serve those who can afford them, pharmacies fill everyday gaps, and informal providers become the first point of care for the urban poor. This diversity is usually framed as a problem, seen as evidence of weak governance and system failure. But what if fragmentation is not the real issue? What if the real challenge is our failure to recognise and organise the plurality that already exists?

This question sat at the heart of a recent CHORUS webinar titled 'From Fragmentation to Harmonisation: Strengthening Urban Health Systems through provider partnerships and collaborations: findings from cities in low- and middle-income countries', which brought together researchers, stakeholders and experts from Ghana, Nigeria, Nepal, and Bangladesh to rethink how urban health systems function in practice.

Cities do not have one health system, they have many

Urbanisation has created health ecosystems rather than a single, unified system. For low-income and mobile populations, healthcare is navigated through proximity, trust and affordability rather than policy design. Informal providers, drug/medicine sellers and small private clinics are not operating at the margins of the system, they are central to how care is accessed every day.

CHORUS research across the four countries shows a consistent pattern: Informal and private providers are often the most accessible and trusted actors in urban settings, particularly in slums. Ignoring them does not improve quality or equity; instead, it leaves large parts of the system ungoverned. The challenge, therefore, is not to eliminate plurality, but to work with it.

When informality becomes an asset

In Nigerian cities, limited public primary healthcare has made informal providers unavoidable. What is changing is the relationship between the state and these providers. With guidance, supervision and community involvement, informal providers are increasingly being seen as contributors rather than obstacles. This shift has reduced mistrust, improved referral practices and strengthened links between community-based care and formal health facilities.

Bangladesh reflects a similar reality. Informal providers already act as first responders in dense urban settlements, particularly amid changing disease patterns and frequent climate related shocks. Here, attention is moving toward strategic purchasing, a deliberate effort to link financing with clearly defined services, standards and outcomes across public and private providers. Rather than funding facilities in isolation, the aim is to connect diverse providers into a more coherent urban primary healthcare network.

Pharmacies as the quiet backbone of urban care

In Nepal, pharmacies illustrate both the promise and the risk of plurality. They are often the most visible and accessible point of contact with the health system, especially as non-communicable diseases dominate the urban disease burden. At the same time, weak regulation and inconsistent practices raise serious concerns about quality and patient safety.

Yet, CHORUS highlighted that the pharmacies do not need to be side-lined to protect standards. With appropriate regulation, training and digital integration, they can support continuity of care, improve access to essential services such as family planning, as well as the growing needs of those with non-communicable diseases such as diabetes and hypertension. This can help reduce unnecessary out-of-pocket spending in expensive private clinics or lost income for informal workers who would otherwise miss out on wages to be seen at public facilities during working hours. When guided effectively, plurality becomes a strength rather than a source of chaos.

Access is more than infrastructure

Ghana's experience adds an important dimension to the conversation. Access is not only about the availability of facilities or services; it is also social and cultural. Large urban health facilities can feel distant or unwelcoming to low-income populations, even when services are officially available. According to Dr Andrews Ayim, Deputy Director of Public Health, Ghana Health Services, *"in Ghana, facilities that are built in the urban areas were huge facilities that culturally were not accessible to the income groups, because even the dress to wear to hospital itself could be a deterrent to that lower [income] group."*

By linking these facilities with pharmacies, community level providers and insurance mechanisms, Ghana is attempting to bridge the invisible barriers that keep people away from care. Rather than focusing solely on expanding infrastructure, the emphasis is on building networks that connect actors across different levels of the system to improve reach, trust and efficiency.

Harmonisation, not homogenisation

The lesson emerging from these diverse contexts is clear. Strengthening urban health systems does not mean forcing uniformity. It means harmonisation. Aligning roles, standards and accountability across a plural set of providers requires mapping who delivers care, understanding their capacities, assigning services deliberately, and using data to guide decisions. Evidence based policy, stronger governance accountable to patients and communities, and sustained collaboration with local governments are essential to make this work. Without these elements, plurality risks deepening inequities. With them, it can become the foundation of resilient urban healthcare.

Rethinking fragmentation

Fragmentation in service provision is often treated as a diagnosis. The experiences from Ghana, Nigeria, Nepal, and Bangladesh suggest it may be better understood as a symptom of unmanaged plurality. Cities are not broken because they have many providers. They struggle because those providers are rarely connected.

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